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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO September 13, 2013
BY Ian K. McClone ANALYST

**BEFORE THE**
**PHYSICIAN ASSISTANT BOARD**
**MEDICAL BOARD OF CALIFORNIA**
**DEPARTMENT OF CONSUMER AFFAIRS**
**STATE OF CALIFORNIA**

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| In the Matter of the Accusation Against:<br><br>Kay Dee Roberts, P.A.<br>6631 Almond Valley Way<br>Lancaster, California 93536<br><br>Physician Assistant License Number PA11543,<br><br>Respondent. | Case No. 1E- 2011-212574<br><br>**A C C U S A T I O N** |

Complainant alleges:

PARTIES

1. Glenn L. Mitchell, Jr. (Complainant) brings this Accusation solely in his official capacity as the Executive Officer of the Physician Assistant Board, Department of Consumer Affairs (Board).

2. On or about August 13, 1984, the Board issued Physician Assistant License number PA11543 to Kay Dee Roberts, P.A. (Respondent). That license was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2015, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws.

4. Business and Professions Code section 3504 provides for the existence of the Board within the Medical Board of California (Medical Board).[1]

5. Section 3527 of the Code provides, in pertinent part:

"(a) The board may order . . . the suspension or revocation of, or the imposition of probationary conditions upon a physician assistant license after a hearing as required in Section 3528 for unprofessional conduct that includes, but is not limited to, a violation of this chapter [Physician Assistant Practice Act (Section 3500, et. seq.)], a violation of the Medical Practice Act [Section 2000, et. seq.], or a violation of the regulations adopted by the board or the Medical Board of California.

". . . .

"(f) The board may order the licensee to pay the costs of monitoring the probationary conditions imposed on the license.

". . . ."

6. California Code of Regulations, title 16, section 1399.521 states:

"In addition to the grounds set forth in section 3527, subdivision (a), of the Code, the committee[2] may deny, issue subject to terms and conditions, suspend, revoke or place on probation a physician assistant for the following causes:

"(a) Any violation of the State Medical Practice Act which would constitute unprofessional conduct for a physician and surgeon.

"...

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[1] All further statutory references are the Business and Professions Code unless otherwise indicated.

[2] Wherever it appears in Title 16 of the California Code of Regulations, "committee" refers to the Physician Assistant Board, formerly named the Physician Assistant Committee by section 3504 of the Code, which was repealed and replaced by a new section 3504 on January 1, 2013.

"(d) Performing medical tasks which exceed the scope of practice of a physician assistant as prescribed in these regulations."

7. Section 3502 of the Code states:

"(a) Notwithstanding any other provision of law, a physician assistant may perform those medical services as set forth by the regulations of the board when the services are rendered under the supervision of a licensed physician and surgeon who is not subject to a disciplinary condition imposed by the board prohibiting that supervision or prohibiting the employment of a physician assistant.

". . . .

"(c)(1) A physician assistant and his or her supervising physician and surgeon shall establish written guidelines for the adequate supervision of the physician assistant. This requirement may be satisfied by the supervising physician and surgeon adopting protocols for some or all of the tasks performed by the physician assistant. The protocols adopted pursuant to this subdivision shall comply with the following requirements:

"(A) A protocol governing diagnosis and management shall, at a minimum, include the presence or absence of symptoms, signs, and other data necessary to establish a diagnosis or assessment, any appropriate tests or studies to order, drugs to recommend to the patient, and education to be provided to the patient.

"(B) A protocol governing procedures shall set forth the information to be provided to the patient, the nature of the consent to be obtained from the patient, the preparation and technique of the procedure, and the follow-up care.

"(C) Protocols shall be developed by the supervising physician and surgeon or adopted from, or referenced to, texts or other sources.

"(D) Protocols shall be signed and dated by the supervising physician and surgeon and the physician assistant.

"(2) The supervising physician and surgeon shall review, countersign, and date a sample consisting of, at a minimum, 5 percent of the medical records of patients treated by the physician assistant functioning under the protocols within 30 days of the date of treatment by the physician

assistant. The physician and surgeon shall select for review those cases that by diagnosis, problem, treatment, or procedure represent, in his or her judgment, the most significant risk to the patient.

". . . ."

8. Section 3502.1 of the Code states:

"(a) In addition to the services authorized in the regulations adopted by the board, and except as prohibited by Section 3502, while under the supervision of a licensed physician and surgeon or physicians and surgeons authorized by law to supervise a physician assistant, a physician assistant may administer or provide medication to a patient, or transmit orally, or in writing on a patient's record or in a drug order, an order to a person who may lawfully furnish the medication or medical device pursuant to subdivisions (c) and (d).

"(1) A supervising physician and surgeon who delegates authority to issue a drug order to a physician assistant may limit this authority by specifying the manner in which the physician assistant may issue delegated prescriptions.

"(2) Each supervising physician and surgeon who delegates the authority to issue a drug order to a physician assistant shall first prepare or adopt a written, practice specific, formulary and protocols that specify all criteria for the use of a particular drug or device, and any contraindications for the selection. The drugs listed shall constitute the formulary and shall include only drugs that are appropriate for use in the type of practice engaged in by the supervising physician and surgeon. When issuing a drug order, the physician assistant is acting on behalf of and as an agent for a supervising physician and surgeon.

"(b) "Drug order" for purposes of this section means an order for medication which is dispensed to or for a patient, issued and signed by a physician assistant acting as an individual practitioner within the meaning of Section 1306.02 of Title 21 of the Code of Federal Regulations. Notwithstanding any other provision of law, (1) a drug order issued pursuant to this section shall be treated in the same manner as a prescription or order of the supervising physician, (2) all references to "prescription" in this code and the Health and Safety Code shall include drug orders issued by physician assistants pursuant to authority granted by their supervising

physicians, and (3) the signature of a physician assistant on a drug order shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.

"(c) A drug order for any patient cared for by the physician assistant that is issued by the physician assistant shall either be based on the protocols described in subdivision (a) or shall be approved by the supervising physician before it is filled or carried out.

"(1) A physician assistant shall not administer or provide a drug or issue a drug order for a drug other than for a drug listed in the formulary without advance approval from a supervising physician and surgeon for the particular patient. At the direction and under the supervision of a physician and surgeon, a physician assistant may hand to a patient of the supervising physician and surgeon a properly labeled prescription drug prepackaged by a physician and surgeon, manufacturer as defined in the Pharmacy Law, or a pharmacist.

"(2) A physician assistant may not administer, provide or issue a drug order for Schedule II through Schedule V controlled substances without advance approval by a supervising physician and surgeon for the particular patient.

"(3) Any drug order issued by a physician assistant shall be subject to a reasonable quantitative limitation consistent with customary medical practice in the supervising physician and surgeon's practice.

"(d) A written drug order issued pursuant to subdivision (a), except a written drug order in a patient's medical record in a health facility or medical practice, shall contain the printed name, address, and phone number of the supervising physician and surgeon, the printed or stamped name and license number of the physician assistant, and the signature of the physician assistant. Further, a written drug order for a controlled substance, except a written drug order in a patient's medical record in a health facility or a medical practice, shall include the federal controlled substances registration number of the physician assistant. The requirements of this subdivision may be met through stamping or otherwise imprinting on the supervising physician and surgeon's prescription blank to show the name, license number, and if applicable, the federal controlled substances number of the physician assistant, and shall be signed by the physician assistant.

When using a drug order, the physician assistant is acting on behalf of and as the agent of a supervising physician and surgeon.

"(e) The medical record of any patient cared for by a physician assistant for whom the supervising physician and surgeon's drug order has been issued or carried out shall be reviewed and countersigned and dated by a supervising physician and surgeon within seven days.

"(f) All physician assistants who are authorized by their supervising physicians to issue drug orders for controlled substances shall register with the United States Drug Enforcement Administration (DEA)."

9. Title 16 of the California Code of Regulations, section 1399.540[3] provides:

"(a) A physician assistant may only provide those medical services which he or she is competent to perform and which are consistent with the physician assistant's education, training, and experience, and which are delegated in writing by a supervising physician who is responsible for the patients cared for by that physician assistant.

"(b) The writing which delegates the medical services shall be known as a delegation of services agreement. A delegation of services agreement shall be signed and dated by the physician assistant and each supervising physician. A delegation of services agreement may be signed by more than one supervising physician only if the same medical services have been delegated by each supervising physician. A physician assistant may provide medical services pursuant to more than one delegation of services agreement.

"(c) The committee or division or their representative may require proof or demonstration

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[3] This version of 16 California Code of Regulations section 1399.540 became operative on August 7, 2008. The prior version provided:

"A physician assistant may only provide those medical services which he or she is competent to perform and which are consistent with the physician assistant's education, training, and experience, and which are delegated in writing by a supervising physician who is responsible for the patients cared for by that physician assistant. The committee or division or their representative may require proof or demonstration of competence from any physician assistant for any tasks, procedures or management he or she is performing. A physician assistant shall consult with a physician regarding any task, procedure or diagnostic problem which the physician assistant determines exceeds his or her level of competence or shall refer such cases to a physician."

of competence from any physician assistant for any tasks, procedures or management he or she is performing.

"(d) A physician assistant shall consult with a physician regarding any task, procedure or diagnostic problem which the physician assistant determines exceeds his or her level of competence or shall refer such cases to a physician."

10. California Code of Regulations, title 16, section 1399.541 states:

"Because physician assistant practice is directed by a supervising physician, and physician assistant acts as an agent for that physician, the orders given and tasks performed by a physician assistant shall be considered the same as if they had been given and performed by the supervising physician. Unless otherwise specified in these regulations or in the delegation or protocols, these orders may be initiated without the prior patient specific order of the supervising physician.

"In any setting, including for example, any licensed health facility, out-patient settings, patients' residences, residential facilities, and hospices, as applicable, a physician assistant may, pursuant to a delegation and protocols where present:

"(a) Take a patient history; perform a physical examination and make an assessment and diagnosis therefrom; initiate, review and revise treatment and therapy plans including plans for those services described in Section 1399.541(b) through Section 1399.541(i) inclusive; and record and present pertinent data in a manner meaningful to the physician.

"(b) Order or transmit an order for x-ray, other studies, therapeutic diets, physical therapy, occupational therapy, respiratory therapy, and nursing services.

"(c) Order, transmit an order for, perform, or assist in the performance of laboratory procedures, screening procedures and therapeutic procedures.

"(d) Recognize and evaluate situations which call for immediate attention of a physician and institute, when necessary, treatment procedures essential for the life of the patient.

"(e) Instruct and counsel patients regarding matters pertaining to their physical and mental health. Counseling may include topics such as medications, diets, social habits, family planning, normal growth and development, aging, and understanding of and long-term management of their diseases.

"(f) Initiate arrangements for admissions, complete forms and charts pertinent to the patient's medical record, and provide services to patients requiring continuing care, including patients at home.

"(g) Initiate and facilitate the referral of patients to the appropriate health facilities, agencies, and resources of the community.

"(h) Administer or provide medication to a patient, or issue or transmit drug orders orally or in writing in accordance with the provisions of subdivisions (a)-(f), inclusive, of Section 3502.1 of the Code.

". . . ."

11. California Code of Regulations, title 16, section 1399.545 states:

"(a) A supervising physician shall be available in person or by electronic communication at all times when the physician assistant is caring for patients.

"(b) A supervising physician shall delegate to a physician assistant only those tasks and procedures consistent with the supervising physician's specialty or usual and customary practice and with the patient's health and condition.

"(c) A supervising physician shall observe or review evidence of the physician assistant's performance of all tasks and procedures to be delegated to the physician assistant until assured of competency.

"(d) The physician assistant and the supervising physician shall establish in writing transport and back-up procedures for the immediate care of patients who are in need of emergency care beyond the physician assistant's scope of practice for such times when a supervising physician is not on the premises.

"(e) A physician assistant and his or her supervising physician shall establish in writing guidelines for the adequate supervision of the physician assistant which shall include one or more of the following mechanisms:

"(1) Examination of the patient by a supervising physician the same day as care is given by the physician assistant;

"(2) Countersignature and dating of all medical records written by the physician assistant within thirty (30) days that the care was given by the physician assistant;

"(3) The supervising physician may adopt protocols to govern the performance of a physician assistant for some or all tasks. The minimum content for a protocol governing diagnosis and management as referred to in this section shall include the presence or absence of symptoms, signs, and other data necessary to establish a diagnosis or assessment, any appropriate tests or studies to order, drugs to recommend to the patient, and education to be given the patient. For protocols governing procedures, the protocol shall state the information to be given the patient, the nature of the consent to be obtained from the patient, the preparation and technique of the procedure, and the follow-up care. Protocols shall be developed by the physician, adopted from, or referenced to, texts or other sources. Protocols shall be signed and dated by the supervising physician and the physician assistant. The supervising physician shall review, countersign, and date a minimum of 5% sample of medical records of patients treated by the physician assistant functioning under these protocols within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent, in his or her judgment, the most significant risk to the patient;

"(4) Other mechanisms approved in advance by the committee.

". . ."

12. Section 2234 of the Code states:

"The [Medical] board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter [Chapter 5, the Medical Practice Act].

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

". . . .

". . . ."

13. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

RELEVANT DRUG LAWS

14. The Uniform Controlled Substances Act, Health and Safety Code section 11055 includes the following drugs as Schedule II controlled substances: codeine; hydrocodone; morphine; oxycodone; and fentanyl. [4]

15. The Uniform Controlled Substances Act, Health and Safety Code section 11057 includes clonazepam as a schedule IV controlled substance.[5]

COST RECOVERY

16. Section 125.3 of the Code states, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of

[4] All of these medications are used for pain relief.
[5] Clonazepam is used to treat seizure disorders or panic disorder.

the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FIRST CAUSE FOR DISCIPLINE

(GROSS NEGLIGENCE)

17. Respondent is subject to disciplinary action under sections 2234, subdivision (b), 3502, 3502.1 of the Code and Title 16 of the California Code of Regulations, sections 1399.521, 1399.540, 1399.541, and 1399.545, in that he was grossly negligent in his care and treatment of patient M.H. The circumstances are as follows:

18. Prior to July 7, 2007, Respondent and G.M., a physician, were employed by Garrison Family Medical Group in Palmdale, California.

19. On or about July 7, 2007, G.M. and Respondent opened the Joshua Medical Group in Palmdale, California.

20. Patient M.H. began treating with Respondent and G.M. at Garrison Family Medical Group. Upon the opening of the Joshua Medical Group, M.H. sought treatment with Respondent and G.M. at the new practice.

21. Medical documentation from the Garrison Family Medical Group includes the following relevant medical history for M.H.

A. M.H. suffered broken ribs, knee and shoulder injuries, brain injury, anxiety, and chronic pain as a result of a motor vehicle versus pedestrian accident, for which he was concurrently treating with T.N., D.O., located in Lancaster, California;

B. M.H. was opioid dependent;

C. M.H. suffered from chronic obstructive pulmonary disease (COPD).

22. A "Current Medication List" for M.H., located in the Joshua Medical Group records, contains a listing of the following medications with notations of "Date Checked."

A. Norco (acetaminophen and hydrocodone), for pain, with check marks on September 25, 2007, October 2, 2007, April 11, 2008, and June 9, 2008;

B. Klonopin (clonazepam), for anxiety, with check marks on September 25, 2007, October 2, 2007, an unspecified date, April 11, 2008, and June 9, 2008;

C. Seroquel (quetiapine)[6] with check marks on July 20, 2007, September 25, 2007, October 2, 2007, April 11, 2008, and June 9, 2008, and a notation for a refill on an unspecified date;

D. Cymbalta (duloxetine)[7] with notes indicated the drug was discontinued on September 25, 2007 and October 2, 2007, refilled on an unspecified date and with check marks for April 11, 2008 and June 9, 2008; and

E. Avinza (morphine sulphate), for pain, with a note indicated it was prescribed on October 2, 2007 and with check marks on April 11, 2008 and June 9, 2008.

23. A Controlled Substance Utilization Review and Evaluation System (CURES) report in M.H.'s medical records obtained by Joshua Medical Group on or about September 4, 2007, reflects that from May 5, 2007, to August 15, 2007, M.H. had been prescribed the following controlled substances:

| Date | Drug Name | Strength | Quantity | Prescribing Physician |
|---|---|---|---|---|
| 5/05/2007 | Oxycodone | 80 mg | 90 | T.N. |
| 5/10/2007 | APAP/Hydrocodone Bitartrate (acetaminophen and hydrocodone) | 325 mg/10 mg | 180 | T.N. |
| 5/12/2007 | Clonazepam | 1 mg | 60 | T.N. |
| 5/24/2007 | Oxycodone HCL | 20 mg | 90 | T.N. |
| 5/27/2007 | Fentanyl | 50 mcg/hr | 10 | T.N. |
| 5/31/2007 | OxyContin (Oxycodone) | 40 mg | 30 | G.M. |
| 6/03/2007 | Oxycodone | 80 mg | 90 | T.N. |
| 6/17/2007 | Clonazepam | 1 mg | 60 | T.N. |
| 6/23/2007 | Norco | 325 mg/10 mg | 180 | T.N. |
| 6/24/2007 | OxyContin | 20 mg | 90 | T.N. |
| 6/25/2007 | Duragesic (Fentanyl) | 50 mcg/hr | 10 | T.N. |
| 6/28/2007 | OxyContin | 40 mg | 36 | T.N. |
| 7/02/2007 | Oxycodone HCL | 80 mg | 90 | T.N. |
| 7/16/2007 | Clonazepam | 1 mg | 60 | T.N. |
| 7/24/2007 | Fentanyl | 25 mcg/hr | 10 | T.N. |
| 8/03/2007 | APAP/Hydrocodone Bitartrate | 750 mg/7.5 mg | 18 | E.P., DDS |
| 8/06/2007 | APAP/Hydrocodone Bitartrate | 750 mg/7.5 mg | 18 | E.P., DDS |
| 8/09/2007 | Norco | 325 mg/10 mg | 180 | T.N. |
| 8/09/2007 | OxyContin | 20 mg | 90 | T.N. |
| 8/09/2007 | OxyContin | 80 mg | 90 | T.N. |
| 8/15/2007 | Clonazepam | 1 mg | 60 | T.N. |

[6] This medication is indicated for the treatment of schizophrenia. It is also prescribed to treat anxiety. It is not a controlled substance.

[7] This medication is indicated for the treatment of depression. It is not a controlled substance.

No other CURES report was ordered by Respondent or G.M. after September 4, 2007.

24. On July 20, 2007, M.H. was seen by Respondent. The progress note contains an assessment which includes intractable pain, insomnia, COPD and osteoarthritis. The progress note indicates that Respondent prescribed Seroquel. No current medications are listed in the progress note; rather, there is a notation to see the Current Medication List. The medication list for this date indicates that M.H. is taking only Seroquel.

25. M.H. was again seen by Respondent on August 28, 2007. At that time, current medications listed in the progress note are Norco, OxyContin, and Cymbalta. The assessment is intractable pain, opiate withdrawal, diarrhea, insomnia, and degenerative joint disease in the shoulder. There is a note that M.H.'s "pain Dr." wrote a prescription for pain medication in a strength that did not exist. As a result, M.H. attempted to use other pain medications and then ran out of the medications. M.H. complained he suffered from withdrawal symptoms. There is no note indicating that either G.M. or Respondent followed up with M.H.'s pain doctor. No medications are listed in the Current Medication List for this date.

26. M.H. next saw Respondent on September 25, 2007. The progress note contains no list of current medications, but contains a notation to see the Current Medication List. The progress note states that M.H. fell and injured his back. It also states that Dr. T.N. decreased M.H.'s dosage of OxyContin, and M.H. would like additional OxyContin from Joshua Medical Group. K.R. ordered a re-fill of OxyContin. The Current Medication List for this date contains notations for Norco, Klonopin, Seroquel, and notes that Cymbalta is discontinued. There is a notation for OxyContin, but it is crossed out.

27. G.M. saw M.H. on October 2, 2007. M.H. complained of severe knee pain. The assessment includes chronic pain, depression and knee degenerative joint disease. There is a notation that M.H. is to be seen for a psychiatric evaluation. The progress note also indicates that Dr. T.N. is on vacation and that M.H. needs Norco for his knee pain. Respondent prescribed OxyContin, Norco, and Klonopin. The corresponding Current Medication List for this date indicates that M.H. was taking Norco, Klonopin, Seroquel, and Avinza. OxyContin is listed, but

crossed out. Cymbalta was discontinued. There is no subsequent record indicating that Respondent or G.M. followed up with a psychiatrist after the evaluation.

28. In October 2007, M.H. underwent a ventral hernia repair surgery.

29. Respondent saw M.H. on October 18, 2007. The progress note contains a notation to see the Current Medication Sheet for M.H.'s medications. The note states that M.H. is running out of OxyContin and Norco and needs a refill. The assessment is chronic intractable pain, osteoarthritis and lumbar disc disease. Respondent ordered and then cancelled a refill of OxyContin. He prescribed Norco.

30. M.H. returned to see Respondent on October 22, 2007, at which time M.H.'s complaints were of severe back pain, right shoulder pain, and right knee pain. Under current medications, the progress note again advises to see the Current Medication List. M.H. advised that he was running out of pain pills after his son stated that a friend knocked the pills into a trash can. The neurological and extremities examinations were within normal limits. Yet, Respondent prescribed OxyContin and advised M.H. to follow up with the pain doctor. There is no corresponding entry in the Current Medication List for this visit.

31. M.H. saw Respondent again on November 27, 2007, for pain and urinary frequency. He was prescribed Klonipin, Flomax (a medication used to improve urination), and Avinza. The progress note contains a notation to see the Current Medication List of M.H.'s medications, but there are no notations in the Current Medication List that correspond with this visit.

32. M.H. returned to see Respondent on November 30, 2007, complaining of rib pain. He was prescribed Norco and told to continue on his current prescriptions. Again, the progress note contains a notation to see the Current Medication List of M.H.'s medications, but there are no notations in the Current Medication List that correspond with this visit.

33. M.H. saw Respondent on December 7, 2007. There is a notation that M.H.'s pain is better with Avinza and that M.H. has an appointment for an evaluation and possible shoulder surgery. The plan is to continue with the current prescriptions and to follow up with the pain management doctor. The progress note contains a notation to see the Current Medication List of

M.H.'s medications, but there are no notations in the Current Medication List that correspond with this visit.

34. M.H. saw Respondent on December 19, 2007 with complaints of a rash. A cream was prescribed, and Avinza was refilled. The progress note contains a notation to see the Current Medication List of M.H.'s medications, but there are no notations in the Current Medication List that correspond with this visit.

35. At a January 19, 2008, visit, Respondent refilled M.H.'s OxyContin and Avinza prescription. He notes that M.S. is scheduled for knee surgery. The progress note contains a notation to see the Current Medication List of M.H.'s medications, but there are no notations in the Current Medication List that correspond with this visit.

36. At a February 7, 2008, Respondent refilled M.H.'s Klonopin. The progress note contains a notation to see the Current Medication List of M.H.'s medications, but there are no notations in the Current Medication List that correspond with this visit.

37. At a February 23, 2008 visit, Respondent refilled M.H.'s prescription for Avinza. There is no notation of current medications on the progress note, and there are no prescriptions for this date noted in the Current Medication List.

38. On March 15, 2008, K.R. again refilled M.H.'s Avinza and Klonopin. The progress note contains a notation to see the Current Medication List of M.H.'s medications, but there are no notations in the Current Medication List that correspond with this visit.

39. M.H. was seen by Respondent on April 11, 2008 for a refill of pain medication. Respondent ordered a refill of Avinza. The progress note contains a notation to see the Current Medication List of M.H.'s medications. The Current Medication List contains check marks for Avinza, Cymbalta, Seroquel, Klonopin, and Norco.

40. On May 9, 2008, Respondent saw M.H. and refilled M.H.'s Seroquel. The progress note contains a notation to see the Current Medication List of M.H.'s medications, but there are no notations in the Current Medication List that correspond with this visit.

41. On August 11, 2008, Respondent saw M.H. and refilled his Norco prescription. There is no notation of current medications on the progress note, and there are no prescriptions for this date noted in the Current Medication List.

42 On September 25, 2008, Respondent's assessment of M.H. was a ventral hernia. The progress note indicates that M.H. has been scheduled for surgery. Respondent completed a pre-operative physical, which included a chest x-ray, electrocardiogram (EKG) and lab work. The pre-operative physical did not include the following information:

A. Complete list of medical problems, including COPD, depression, narcotic dependence, and prior hernia;

B. List of specialists providing care to M.H.;

C. Complete list of current medications;

D. Follow-up on the chest x-ray finding of bronchitis;

E. Review of the pre-operative EKG.

43. M.H.'s hernia surgery was performed in an out-patient surgery center on October 2, 2008, and he was sent home on the same date. Thereafter, he developed diarrhea. By October 7, 2008, the diarrhea became uncontrolled. Paramedics were called, but by the time they arrived, M.H. had become unresponsive and was unable to be resuscitated.

44. An autopsy was completed, and the cause of death was determined to be occlusive coronary atherosclerosis. The manner of death was undetermined.

45. From the inception of the Joshua Medical Group practice until on or about October 2, 2008, no Delegation of Services Agreement or written protocols existed between Respondent and Respondent.

46. From the inception of the Joshua Medical Group practice up to October 2008, there existed no requirement that Respondent obtain advance approval to prescribe a controlled substance.

47. From the inception of the Joshua Medical Group practice up to on or about October 1, 2008, Respondent had not completed an approved controlled substance education course to

provide Schedule II-V controlled substances without advance approval from a supervising physician, as defined by California Code of Regulations, title 16, section 1399.610.

48. From the inception of the Joshua Medical Group practice up to on or about October 2, 2008, there existed no requirement for review of Respondent's care prior to referral for surgery.

49. There was no patient-physician contract covering the prescription and use of controlled substances between Joshua Medical Group and M.H.

50. Respondent was grossly negligent in his treatment of M.H. as follows:

A. Respondent was grossly negligent in that he exceeded the scope of practice of a physician assistant in the prescription of controlled substances when he:

1) Prescribed controlled substances to M.H. in the absence of a delegation of services agreement or written protocols specifying criteria for prescription of the controlled substances; and/or

2) Prescribed controlled substances to M.H. without advance approval from G.M.; and/or

3) Prescribed controlled substances to M.H. without having completed an approved controlled substance education course to provide Schedule II-V controlled substances without advance approval from a supervising physician; and/or

4) Prescribed controlled substances to M.H. in the absence of a patient-physician contract covering the prescription and use of controlled substances between Joshua Medical Group and M.H.

B. Respondent was grossly negligence in his completion of a pre-operative physical in that he failed to failed to:

1) Complete list of medical problems, including COPD, depression, narcotic dependence, and prior hernia; and/or

2) List of specialists providing care to M.H.; and/or

3) Complete list of current medications; and/or

4) Follow-up on the chest x-ray finding of bronchitis; and/or

5) Review the pre-operative EKG.

51. Respondent's acts and/or omissions as set forth in paragraphs 18 through 49, inclusive, above, whether proven individually, jointly, or in any combination thereof, constitute gross negligence. Therefore, cause for discipline exists.

SECOND CAUSE FOR DISCIPLINE

(REPEATED NEGLIGENT ACTS)

52. By reason of the facts set forth in paragraphs 18 through 49, Respondent is subject to disciplinary action under Sections 2234, subdivision (c), 3502, 3502.1 of the Code, and Title 16 of the California Code of Regulations, sections 1399.521, 1399.540, 1399.541, and 1399.545, in that Respondent committed repeated negligent acts in his care and treatment of M.H.

THIRD CAUSE FOR DISCIPLINE

(FAILURE TO MAINTAIN ACCURATE AND ADEQUATE RECORDS)

53. By reason of the facts set forth in paragraphs 18 through 48, Respondent is subject to disciplinary action under Section 2266 of the Code in that Respondent failed to maintain adequate and accurate records.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board issue a decision:

1. Revoking or suspending Physician Assistant Certificate Number PA11543, issued to Respondent;

2. Ordering Respondent to pay the Physician Assistant Committee the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: September 13, 2013

GLENN L. MITCHELL, JR.
Executive Officer
Physician Assistant Committee
Department of Consumer Affairs
State of California
*Complainant*

LA2012604571